PA 18-166—sSB 483
Judiciary Committee

AN ACT CONCERNING THE PREVENTION AND TREATMENT OF OPIOID DEPENDENCY AND OPIOID OVERDOSES IN THE STATE

SUMMARY: This act makes various changes concerning the prevention and treatment of opioid drug abuse and related issues. It:

1. requires the chief court administrator to study the feasibility of establishing an opioid intervention court;
2. prohibits prescribing practitioners ("prescribers") from prescribing, dispensing, or administering schedule II to IV controlled substances to themselves or immediate family members, except in emergencies;
3. allows prescribers or pharmacists authorized to prescribe naloxone to enter into an agreement to distribute opioid antagonists to certain entities (e.g., community health organizations and law enforcement agencies);
4. requires the Alcohol and Drug Policy Council to convene a working group to evaluate methods of combating the opioid epidemic;
5. requires any hospital or emergency medical services personnel that treats a patient for an opioid overdose to report the overdose to the Department of Public Health (DPH) starting in 2019, and requires DPH to report such data to the local health department or district starting in 2020; and
6. extends a Department of Correction (DOC) pilot methadone treatment program, expands its scope if federal funds are available, and requires various related reports.

EFFECTIVE DATE: July 1, 2018, except the provisions on the chief court administrator study, Alcohol and Drug Policy Council working group, and DOC pilot methadone treatment program are effective upon passage.

§ 1 — OPIOID INTERVENTION COURT FEASIBILITY STUDY

The act requires the chief court administrator or his designee, in consultation with the chief public defender, the chief state's attorney, and the dean of UConn's School of Law, or their designees, to study the feasibility of establishing one or more courts that specialize in hearing criminal or juvenile matters where a defendant is an opioid-dependent person who could benefit from intensive court monitoring and placement in a substance abuse treatment program.

The study must examine:

1. the testing of certain arrestees for opioid use and the timing of the tests,
2. innovative and different treatment placement options for opioid-dependent arrestees,
3. the development of a rapid integration team of individuals who focus on

meeting the treatment needs of such arrestees,
4. the development of judicial processes that include daily court monitoring of such arrestees, and
5. the use of curfews and electronic monitoring to facilitate successful program completion.

By January 1, 2019, the act requires the chief court administrator or his designee to report the study results to the Judiciary Committee.

§ 2 — PROVISION OF CONTROLLED SUBSTANCES TO SELF OR FAMILY

Under the act, prescribers generally may not prescribe, dispense, or administer schedule II to IV controlled substances to themselves or immediate family members. An "immediate family member" is a spouse; parent; child; sibling; parent-in-law; son- or daughter-in-law; brother- or sister-in-law; step-parent, -child, or -sibling; or other relative residing with the prescriber. Animals living with the prescriber are not considered immediate family members for these purposes.

In an emergency, the act allows prescribers to prescribe, dispense, or administer up to a 72-hour supply of a schedule II to IV controlled substance to themselves or immediate family members, but only if there is no other qualified prescriber available. If prescribing, dispensing, or administering a controlled substance to an immediate family member, the prescriber must (1) assess the patient's care and treatment; (2) medically evaluate the patient's need for the controlled substance; (3) document the assessment and patient's need in the normal course of his or her business; and (4) document the emergency.

§ 3 — OPIOID ANTAGONIST PROGRAM

The act authorizes prescribers or pharmacists certified to prescribe naloxone (an opioid antagonist) to enter into an agreement with a law enforcement agency, emergency medical service ("EMS") provider, government agency, or community health organization ("agencies") concerning the distribution and administration of opioid antagonists. The agreement must address the agencies' opioid antagonist storage, handling, labeling, recalls, and recordkeeping.

The prescriber or pharmacist must provide training to the individuals who will distribute or administer opioid antagonists under such an agreement. Additionally, the act requires individuals who will distribute or administer opioid antagonists to receive training before doing so.

Under the act, prescribers or pharmacists who enter into an agreement as permitted by the act cannot, as a result of an agency's administration or dispensing of an opioid antagonist, be (1) held liable for damages in a civil action or (2) subjected to administrative or criminal prosecution.

The act authorizes the consumer protection commissioner to adopt regulations implementing these provisions.

§ 4 — ALCOHOL AND DRUG POLICY COUNCIL WORKING GROUP

The act requires the Alcohol and Drug Policy Council to convene a working group to evaluate methods of combating the opioid epidemic in the state. The working group must investigate and advise the council's chairpersons on:

1. the number of people annually receiving services from each methadone treatment program funded by a Department of Mental Health and Addiction Services (DMHAS) contract, the rate at which such people relapse, and the number of people who die from a drug overdose while participating in such program;
2. the availability of opioid antagonists at such methadone and state-funded treatment programs for people with substance use disorders;
3. the advantages and disadvantages of allowing a licensed mental health professional at each methadone treatment program and treatment program for people with substance use disorder to dispense an opioid antagonist directly to a person at discharge without having him or her go to a pharmacy to obtain it;
4. whether a nonfatal drug overdose at a hospital or outpatient surgical facility should qualify as an adverse event (which would require the facility to report such overdoses to DPH);
5. the role of health carriers in shortening a person's stay at a treatment program for people with substance use disorders;
6. the availability of federal funds to supply EMS personnel in the state with opioid antagonists and train them in administering such drugs;
7. the development and implementation of a statewide uniform prehospital data reporting system to capture the demographics of prehospital administration or use of opioid antagonists and the opioid reversal outcomes due to such administration or use;
8. the development of a statewide strategy to (a) identify potential federal funding sources for treating and preventing opioid use disorders and (b) maximize federal reimbursement and grant funding for state initiatives in combatting the opioid epidemic in the state; and
9. whether using physical therapy, acupuncture, massage, and chiropractic care can reduce the need for opioid drugs in mitigating a patient's chronic pain.

By January 1, 2019, the working group must report its findings to the Alcohol and Drug Policy Council chairpersons. The chairpersons must then report to the Public Health Committee the findings and any recommendations for legislation.

§ 5 — OVERDOSE REPORTING

Under the act, starting January 1, 2019, any hospital or EMS personnel that treats a patient for an opioid overdose must report the overdose to DPH in a form and manner the commissioner prescribes.

By January 1, 2020, DPH must provide the data to the municipal or district health department that has jurisdiction over the overdose location, or, if that location is unknown, the location in which the hospital or EMS personnel treated the patient, as DPH in its discretion deems necessary to develop preventive initiatives.

Under the act, the data the hospital or EMS personnel reports must remain confidential in accordance with existing law for records provided to DPH.

§§ 6 & 7 — DOC PILOT METHADONE TREATMENT PROGRAM

Prior law allowed DOC to initiate a pilot treatment program for 18 months for methadone maintenance and other drug therapies at correctional facilities. The act extends the pilot program, expands its scope if federal funds are available, and requires a new report on the program's results by July 1, 2019. DOC must submit the report to the Appropriations, Human Services, Judiciary, and Public Health committees. As under prior law, the program must treat 60 to 80 inmates per month.

The act requires DOC, by January 15, 2019, and in consultation with DMHAS, DPH, the Department of Social Services, and the Office of Policy and Management, to review the pilot program and report to the Judiciary and Public Health committees the following:

1. a comprehensive plan for expanding the pilot program to serve all state inmates with opioid use disorders, including estimates of the lives the pilot program saved; the costs; short-and long-term savings, which include savings to other state departments and agencies; and the availability of federal funds to expand the pilot program;
2. opportunities to expand the program without incurring additional costs, including through existing programs that make long-term injectable opioid antagonists available to the state at a reduced cost or no cost; and
3. the feasibility of DOC embedding, within available resources, treatment of opioid use disorders in its health care delivery system.

Under the act, DOC and DMHAS must seek, within available resources, all available federal funds for expanding access to medication-assisted treatment for opioid use disorders in correctional facilities. If federal funds are available, DOC must expand the pilot program, including offering the program in additional facilities, increasing the number of inmates who can access it, or providing partial opioid agonists through the program. By January 1, 2020, the DOC and DMHAS commissioners must report to the Judiciary and Public Health committees the availability of funds and the plan for expanding the pilot program.

Under the act, "long-term injectable opioid antagonist" means naltrexone for extended-release injectable suspension or any other similarly acting and equally safe drug approved by the federal Food and Drug Administration (FDA) for treating opioid use disorder. "Partial opioid agonist" means a medication that (1) binds to the opiate receptors and provides relief to individuals in treating opioid drug abuse or dependency and (2) causes less conformational change and receptor activation in the central nervous system than a full opioid agonist.

BACKGROUND

Prescribing Practitioners

The following health providers may prescribe medication within the scope of their practice: physicians, dentists, podiatrists, optometrists, physician assistants,

advanced practice registered nurses, nurse-midwives, and veterinarians (CGS § 20-14c).

Opioid Antagonists

An "opioid antagonist" is naloxone hydrochloride (e.g., Narcan) or any other similarly acting and equally safe drug that the FDA approved for treating a drug overdose (CGS § 17a-714a).

Pharmacists Authorized to Prescribe Opioid Antagonists

Licensed pharmacists may prescribe opioid antagonists if they (1) have been trained and certified by a program approved by the consumer protection commissioner and (2) act in good faith (CGS § 20-633c).